COMMANDER, NAVAL SURFACE FORCE
UNITED STATES ATLANTIC FLEET
1430 MITSCHER AVENUE
NORFOLK, VIRGINIA 23551-2494
AND
COMMANDER, NAVAL SURFACE FORCE
UNITED STATES PACIFIC FLEET
2841 RENDOVA ROAD
SAN DIEGO, CALIFORNIA 92155-5490

COMNAVSURFLANTINST 6320.3/
COMNAVSURFPACINST 6320.3
CNSL Code N02M/CNSP Code N01M
04 Dec 1997

COMNAVSURFLANT INSTRUCTION 6320.3/COMNAVSURFPAC INSTRUCTION 6320.3

Subj: MEDICAL AND DENTAL CARE FOR U.S. GOVERNMENT CIVILIAN EMPLOYEES AND CONTRACT PERSONNEL EMBARKED ON SURFLANT/SURFPAC SHIPS

Ref: (a) NAVMEDCOMINST 6320.3B

Encl: (1) U.S. Civil Service Commission Certificate of Medical Examination (SF-78)
(2) Report of Medical History (SF 93)

1. **Purpose**. To establish policies regarding provision of medical and dental care to U.S. government civilian employees and contractors while embarked aboard Commander, Naval Surface Force, U.S. Atlantic Fleet (COMNAVSURFLANT)/Commander, Naval Surface Force, U.S. Pacific Fleet (COMNAVSURFPAC) afloat units.

2. **Discussion**. U.S. government civilian employees and contractors frequently deploy with COMNAVSURFLANT/COMNAVSURFPAC vessels. Unstable chronic medical conditions among these personnel can severely strain the limited resources of a ship's medical department. Therefore, these personnel must be medically qualified prior to deployment. Reference (a) provides information on policies and procedures for provision of medical and dental care to eligible persons at Navy medical department facilities. Reference (a) also discusses the care authorized and method of payment for both U.S. government employees and civilian contract personnel. The following guidelines regarding these personnel will be followed:

a. Civilian employees of the U.S. government and civilian contractors with an unstable chronic disease or condition that requires frequent medical monitoring and/or treatment shall not deploy on board COMNAVSURFLANT/COMNAVSURFPAC vessels. A

Certificate of Medical Examination SF-78 (enclosure 1) and Report of Medical History SF-93 (enclosure 2) completed within the previous 12 months shall be submitted to the ship's Senior Medical Department Representative (SMDR) two months prior to deployment. In unforeseen or emergency cases, the employee will present copies of the completed SF-78 and SF-93 to the SMDR as soon as practicable upon arrival. The SMDR will review the documents and, if necessary, perform any additional examinations or referrals required to reach a recommendation regarding fitness for embarkation. The Commanding Officer, with input from the SMDR, will make the final decision regarding fitness for embarkation in all cases.

b. If currently on medication, a U.S. government civilian employee or contractor shall bring a quantity of medications sufficient to last through the deployment period. The individual shall contact the SMDR if any special storage is required for these medications.

c. If emergency medical/dental treatment is required by a U.S. government civilian employee or contractor during deployment, it will be provided per reference (a). If the condition of a U.S. government civilian employee or contractor requires prolonged treatment which exceeds the capacity of the ship's medical department, the individual shall be medically evacuated.

3. **Action**. This instruction is effective upon receipt. SURFLANT/SURFPAC commands shall implement all monitoring and evaluation procedures as soon as practicable.

4. **Forms**. Enclosures (1) and (2) are stocked at Naval Inventory Control Point Phildelphia. Stock number for SF 78 is 7540-00-634-4027 and for SF 93 is 7540-00-181-8368.

W. E. DOUD
Deputy and
Chief of Staff
COMNAVSURFPAC

R. P. PERRY
Deputy and
Chief of Staff
COMNAVSURFLANT

Distribution: (COMNAVSURFLANT) SNDL Parts 1 and 2

26A1	COMPHIBGRU TWO
26C1	COMNAVBEACHGRU TWO
26E1	AMPHIBIOUS UNIT LANT
26W1A	NRCHIB Williamsburg
26DD1	MOBDIVSALU TWO
26FF	COMINEWARINGSGRU
26GG1	COMEODGRU TWO
26QQ1A	COMNAVSPECWARGRU TWO

28 SQD, DIV, AND GRU COMMANDERS LANT (less COMSURFWARDEVGRU Little Creek)
29 WARSHIPS LANT
30 MINE WARFARE SHIPS
31 AMPHIBIOUS SHIPS LANT
32 AUXILIARY SHIPS LANT
36A1 DYNAMIC AFDL 6
39E1A PHIBCB TWO
42T1 TACTICAL AIR CONTROL GROUP AND SQUADRON LANT
FA7 NAVSTA (Norfolk and Mayport only)
FA18 NAVPHIBASE Little Creek
FT43 SWOSCOLCOM

Copy to:
21A1 CINCLANTFLT

Distribution: (COMNAVSURFPAC)
24H2 Fleet Training Command PAC
24J2 Fleet Marine Force Command PAC
26H2 Fleet Training Group PAC
26V2 Amphibious School (Coronado Only)
26VVV2 Fleet Surgical Team PAC
32N2 Oiler Pac (AOR)
32X2 Savage Ship PAC (ARS)
32KK Miscellaneous command ship (AGF) (USS CORONADO only)
36A2 Auxiliary Floating Dry Dock (AFDM) and Auxiliary Repair Dry Dock (ARD) (ARDM), PAC (F only)
39E2 Amphibious Construction Battalion PAC
42T2 Tactical Air Control Group and Squadron PAC (VTC)
FB21 Amphibious Base PAC
FB34 Fleet Activities (COMFEACT Yokosuka only)
FH3 Hospital (San Diego, Bremerton, Yokosuka, and Guam only)
FKP8 Supervisor Shipbuilding, Conversion and Repair, USN (SUPSHIP Pascagoula, Code 154, only)
FT43 Surface Warfare Officers School Command

Copy to:
21A2 CINCPACFLT
24A Naval Air Force Commander PAC
41A Commander, Military Sealift Command
A5 Chief of Naval Personnel (8)
B5 U.S. Coast Guard (Commandant only) (10)
FB59 Dental Clinics PAC (San Diego only) (2)
FH1 Bureau of Medicine and Surgery
FH14 Health Science Education and Training Command
FH28 School of Health Science (San Diego, Portsmouth only) (2)
FR18 Reserve Maintenance Training Facility
Sub-Board of Inspection and Survey PAC (San Diego only)

TO BE GIVEN TO PERSON EXAMINED WITH A PRE-ADDRESSED "CONFIDENTIAL-MEDICAL" ENVELOPE.

UNITED STATES CIVIL SERVICE COMMISSION
CERTIFICATE OF MEDICAL EXAMINATION

Form Approved
Budget Bureau
No. 50-R0073

Part A. TO BE COMPLETED BY APPLICANT OR EMPLOYEE *(typewrite or print in ink)*

1. NAME *(last, first, middle)*	2. SOCIAL SECURITY ACCOUNT NO.	3. SEX ☐ MALE ☐ FEMALE	4 DATE OF BIRTH

5 DO YOU HAVE ANY MEDICAL DISORDER OR PHYSICAL IMPAIRMENT WHICH WOULD INTERFERE IN ANY WAY WITH THE FULL PERFORMANCE OF THE DUTIES SHOWN BELOW? ☐ YES ☐ NO

(If your answer is "YES" explain fully to the physician performing the examination)

6. I CERTIFY THAT ALL THE INFORMATION GIVEN BY ME IN CONNECTION WITH THIS EXAMINATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF

_____
(signature of applicant)

Part B. TO BE COMPLETED BEFORE EXAMINATION BY APPOINTING OFFICER

1. PURPOSE OF EXAMINATION	2. POSITION TITLE
☐ PREAPPOINTMENT ☐ OTHER *(specify)*	

3. BRIEF DESCRIPTION OF WHAT POSITION REQUIRES EMPLOYEE TO DO

4. Circle the number preceding *each* functional requirement and *each* environmental factor essential to the duties of this position. List any additional essential factors in the blank spaces. Also, if the position involves law enforcement, air traffic control, or fire fighting, attach the specific medical standards for the information of the examining physician.

A. FUNCTIONAL REQUIREMENTS

1. Heavy lifting, 45 pounds and over
2. Moderate lifting, 15–44 pounds
3. Light lifting, under 15 pounds
4. Heavy carrying, 45 pounds and over
5. Moderate carrying, 15–44 pounds
6. Light carrying, under 15 pounds
7. Straight pulling (hours)
8. Pulling hand over hand (hours)
9. Pushing (hours)
10. Reaching above shoulder
11. Use of fingers
12. Both hands required
13. Walking (hours)
14. Standing (hours)
15. Crawling (hours)
16. Kneeling (hours)
17. Repeated bending (hours)
18. Climbing, legs only (hours)
19. Climbing, use of legs and arms
20. Both legs required
21. Operation of crane, truck, tractor, or motor vehicle
22. Ability for rapid mental and muscular coordination simultaneously
23. Ability to use and desirability of using firearms
24. Near vision correctable at 13" to 16" to Jaeger 1 to 4
25. Far vision correctable in one eye to 20/20 and to 20/40 in the other
26. Far vision correctable in one eye to 20/50 and to 20/100 in the other
27. Specific visual requirement *(specify)*
28. Both eyes required
29. Depth perception
30. Ability to distinguish basic colors
31. Ability to distinguish shades of colors
32. Hearing *(aid permitted)*
33. Hearing without aid
34. Specific hearing requirement (specify)
35. Other *(specify)*

B. ENVIRONMENTAL FACTORS

1. Outside
2. Outside and inside
3. Excessive heat
4. Excessive cold
5. Excessive humidity
6. Excessive dampness or chilling
7. Dry atmospheric conditions
8. Excessive noise, intermittent
9. Constant noise
10. Dust
11. Silica, asbestos, etc.
12. Fumes, smoke, or gases
13. Solvents *(degreasing agents)*
14. Grease and oils
15. Radiant energy
16. Electrical energy
17. Slippery or uneven walking surfaces
18. Working around machinery with moving parts
19. Working around moving objects or vehicles
20. Working on ladders or scaffolding
21. Working below ground
22. Unusual fatigue factors *(specify)*
23. Working with hands in water
24. Explosives
25. Vibration
26. Working closely with others
27. Working alone
28. Protracted or irregular hours of work
29. Other *(specify)*

Part C. TO BE COMPLETED BY EXAMINING PHYSICIAN

1. EXAMINING PHYSICIAN'S NAME *(type or print)*	3. SIGNATURE OF EXAMINING PHYSICIAN
2. ADDRESS *(including ZIP Code)*	_____ *(signature)* _____ *(date)* IMPORTANT: After signing, return *the entire form intact* in the pre-addressed "Confidential-Medical" envelope which the person you examined gave you.

78-110

STANDARD FORM NO. 78
OCTOBER 1969 (REVISION)
CIVIL SERVICE COMMISSION
FPM 339

Enclosure (1)

NOTE TO EXAMINING PHYSICIAN: The person you are about to examine will have to cope with the functional requirements and environmental factors circled on the other side of this form. Please take them, and the brief description of job duties above them, into consideration as you make your examination and report your findings and conclusions.

1. HEIGHT: _____ FEET, _____ INCHES. WEIGHT: _____ POUNDS.

2. EYES:

(A) Distant vision (Snellen): without glasses: right 20 left 20 ; with glasses, if worn: right 20 left 20

(B) What is the longest and shortest distance at which the following specimen of Jaeger No. 2 type can be read by the applicant? Test each eye separately.

Jaeger No. 2 Type

employees in the Federal classified service as may be requested by the Civil Service Commission or its authorized representative. This order will supplement the Executive Orders of May 22 and June 18, 1923 (Executive Order, September 4, 1924).

	without glasses:	with glasses, if used:
R.	_____ in. to _____ in.	_____ in. to _____ in.
L.	_____ in. to _____ in.	_____ in. to _____ in.

(C) Color vision: Is color vision normal when Ishihara or other color plate test is used? ☐ YES ☐ NO
If not, can applicant pass lantern, yarn, or other comparable test? ☐ YES ☐ NO

3. EARS: (Consider denominators indicated here as normal. Record as numerators the greatest distance heard.)
Ordinary conversation:

RIGHT EAR _____/20 ft.; LEFT EAR _____/20 ft.

Audiometer *(if given)*:

250	500	1000	2000	3000	4000	5000	6000	7000	8000

4. OTHER FINDINGS: In items a through l briefly describe any *abnormality* (including diseases, scars, and disfigurations). Include brief history, if pertinent. If normal, so indicate.

a. Eyes, ears, nose, and throat *(including teeth and oral hygiene)*

b. Head and back *(including face, hair, and scalp)*

c. Speech *(note any malfunction)*

d. Skin and lymph nodes *(including thyroid gland)*

e. Abdomen

f. Peripheral blood vessels

g. Extremities

h. Urinalysis *(if indicated)*
Sp. gr. _____ Sugar _____ Blood _____
Albumen _____ Casts _____ Pus _____

i. Respiratory tract *(X-ray if indicated)*

j. Heart *(size, rate, rhythm, function)*
Blood pressure _____
Pulse _____
EKG *(if indicated)*

k. Back *(special consideration for positions involving heavy lifting and other strenuous duties)*

l. Neurological and mental health

CONCLUSIONS: Summarize below any medical findings which, in your opinion, would limit this person's performance of the job duties and/or would make him a hazard to himself or others. If none, so indicate.

☐ No limiting conditions for this job
☐ Limiting conditions as follows:

FOR AGENCY USE ONLY

Part A. TO BE COMPLETED BY APPLICANT OR EMPLOYEE *(typewrite or print in ink)*

1. NAME *(Last, first, middle)*	2. SOCIAL SECURITY ACCOUNT NO.	3. SEX ☐ MALE ☐ FEMALE	4. DATE OF BIRTH

5. DO YOU HAVE ANY MEDICAL DISORDER OR PHYSICAL IMPAIRMENT WHICH WOULD INTERFERE IN ANY WAY WITH THE FULL PERFORMANCE OF THE DUTIES SHOWN BELOW? ☐ YES ☐ NO

(If your answer is "YES" explain fully to the physician performing the examination)

6. I CERTIFY THAT ALL THE INFORMATION GIVEN BY ME IN CONNECTION WITH THIS EXAMINATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____
(signature of applicant)

Part D. TO BE COMPLETED BY AGENCY MEDICAL OFFICER *(if one is available)*

NOTE: Review the attached certificate of medical examination and make your recommendations in item 1 below. If the medical examination was done for pre-appointment purposes, circle the appropriate handicap code in part F.

1. RECOMENDATION:

☐ HIRE OR RETAIN. DESCRIBE LIMITATIONS, IF ANY, HERE.

☐ TAKE ACTION TO SEPARATE OR DO NOT HIRE. EXPLAIN WHY.

2. AGENCY MEDICAL OFFICER'S NAME *(type or print)*	3. LOCATION *(city, State, ZIP Code)*	4. DATE

Part E. TO BE COMPLETED BY AGENCY PERSONNEL OFFICER

NOTE: Enter the action taken below. If this form is used for pre-appointment purposes, be sure the appropriate handicap code in part F is circled. *IMPORTANT: See FPM Chapter 293, Subchapter 3; FPM Chapter 339 and FPM Supplement 339-31 for disposition and/or filing of both parts of this form, either separately or together.*

1. ACTION TAKEN:

☐ HIRED OR RETAINED. ☐ NON-SELECTED FOR APPOINTMENT, OR ELIGIBILITY OBJECTED TO

☐ ACTION TAKEN TO SEPARATE

2. AGENCY PERSONNEL OFFICER'S NAME *(type or print)*	3. SIGNATURE	4. DATE

Part F. HANDICAP CODE *(to be completed only in pre-appointment cases)*

If the person examined has or had a handicap listed below, circle the code number which pertains to that handicap. If more than one handicap applies, circle the one considered most limiting. If none of the handicap codes apply, circle code "00".

- 00 No handicap of the type listed
- 10 Amputation—one major extremity
- 11 Amputation—two or more major extremities
- 20 Deformity or impaired function—upper extremity
- 21 Deformity or impaired function—lower extremity or back
- 30 Vision—one eye only
- 31 No usable vision
- 40 Hearing aid required
- 41 No usable hearing
- 42 No usable hearing, with speech malfunction
- 43 Normal hearing, with speech malfunction
- 50 Tuberculosis—inactive pulmonary
- 51 Organic heart disease *(compensated)*—valvular, arrhythmia, arteriosclerosis, healed coronary lesions
- 52 Diabetes—controlled
- 53 Epilepsy—adequately controlled
- 54 History of emotional behavioral problems requiring special placement effort
- 55 Mentally retarded
- 56 Mentally recovered

1. EXAMINING PHYSICIAN'S NAME *(type or print)*	3. SIGNATURE OF EXAMINING PHYSICIAN
2. ADDRESS *(including ZIP Code)*	_____ *(signature)* _____ *(date)*

IMPORTANT: After signing, return *the entire form intact* in the pre-addressed "Confidential-Medical" envelope which the person you examined gave you.

☆ GPO : 1986 O - 490-498 (96)

STANDARD FORM 93
REV. OCTOBER 1974
PRESCRIBED BY GSA/ICMR
FIRMR (41 CFR) 201-45.505

APPROVED DEC 04 1997
OFFICE OF MANAGEMENT AND BUDGET No. 29-R0191

REPORT OF MEDICAL HISTORY

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY-CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME		2. SOCIAL SECURITY OR IDENTIFICATION NO.
3. HOME ADDRESS *(No. street or RFD, city or town, State, and ZIP CODE)*		4. POSITION *(title, grade, component)*
5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION	7. EXAMINING FACILITY OR EXAMINER, AND ADDRESS *(Include ZIP Code)*

8. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint exists)*

9. HAVE YOU EVER *(Please check each item)*

YES	NO	(Check each item)
		Lived with anyone who had tuberculosis
		Coughed up blood
		Bled excessively after injury or tooth extraction
		Attempted suicide
		Been a sleepwalker

10. DO YOU *(Please check each item)*

YES	NO	(Check each item)
		Wear glasses or contact lenses
		Have vision in both eyes
		Wear a hearing aid
		Stutter or stammer habitually
		Wear a brace or back support

11. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	(Check each item)
			Scarlet fever, erysipelas
			Rheumatic fever
			Swollen or painful joints
			Frequent or severe headache
			Dizziness or fainting spells
			Eye trouble
			Ear, nose, or throat trouble
			Hearing loss
			Chronic or frequent colds
			Severe tooth or gum trouble
			Sinusitis
			Hay Fever
			Head injury
			Skin diseases
			Thyroid trouble
			Tuberculosis
			Asthma
			Shortness of breath
			Pain or pressure in chest
			Chronic cough
			Palpitation or pounding heart
			Heart trouble
			High or low blood pressure

YES	NO	DON'T KNOW	(Check each item)
			Cramps in your legs
			Frequent indigestion
			Stomach, liver, or intestinal trouble
			Gall bladder trouble or gallstones
			Jaundice or hepatitis
			Adverse reaction to serum, drug, or medicine
			Broken bones
			Tumor, growth, cyst, cancer
			Rupture/hernia
			Piles or rectal disease
			Frequent or painful urination
			Bed wetting since age 12
			Kidney stone or blood in urine
			Sugar or albumin in urine
			VD—Syphilis, gonorrhea, etc.
			Recent gain or loss of weight
			Arthritis, Rheumatism, or Bursitis
			Bone, joint or other deformity
			Lameness
			Loss of finger or toe
			Painful or "trick" shoulder or elbow
			Recurrent back pain

YES	NO	DON'T KNOW	(Check each item)
			"Trick" or locked knee
			Foot trouble
			Neuritis
			Paralysis (include infantile)
			Epilepsy or fits
			Car, train, sea or air sickness
			Frequent trouble sleeping
			Depression or excessive worry
			Loss of memory or amnesia
			Nervous trouble of any sort
			Periods of unconsciousness

12. FEMALES ONLY: HAVE YOU EVER

			Been treated for a female disorder
			Had a change in menstrual pattern

13. WHAT IS YOUR USUAL OCCUPATION?

14. ARE YOU (Check one)
☐ Right handed ☐ Left handed

93-103

Enclosure (2)

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT
		15. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.
		B. Inability to perform certain motions.
		C. Inability to assume certain positions.
		D. Other medical reasons (*If yes, give reasons.*)
		16. Have you ever been treated for a mental condition? (*If yes, specify when, where, and give details.*)
		17. Have you ever been denied life insurance? (*If yes, state reason and give details.*)
		18. Have you had, or have you been advised to have, any operations? (*If yes, describe and give age at which occurred.*)
		19. Have you ever been a patient in any type of hospitals? (*If yes, specify when, where, why, and name of doctor and complete address of hospital.*)
		20. Have you ever had any illness or injury other than those already noted? (*If yes, specify when, where, and give details.*)
		21. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (*If yes, give complete address of doctor, hospital, clinic, and details.*)
		22. Have you ever been rejected for military service because of physical, mental, or other reasons? (*If yes, give date and reason for rejection.*)
		23. Have you ever been discharged from military service because of physical, mental, or other reasons? (*If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability.*)
		24. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? (*If yes, specify what kind, granted by whom, and what amount, when, why.*)

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge.
I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE

NOTE: HAND TO THE DOCTOR OR NURSE. OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."

25. Physician's summary and elaboration of all pertinent data (*Physician shall comment on all positive answers in items 9 through 24. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.*)

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS

REVERSE OF STANDARD FORM 93

☆ U.S. GOVERNMENT PRINTING OFFICE: 1992 – 342-199 / 50185